activity that we can realize with a robust program.

If my colleagues would care to comment, I will be happy to yield.

Mr. JEFFORDS. I thank the Senator for yielding for my comments. I agree with my colleague Senator INHOFE and I look forward to working with him on this major transportation reauthorization bill. He is correct that beginning reauthorization discussions with a low baseline will hinder our efforts in crafting a truly robust national program which will provide strong economic and transportation benefits for all regions. I would be happy to yield back to my colleague Senator REID.

Mr. REID. I agree with my colleagues. The transportation bill will be one of the most important pieces of legislation taken up by the next Congress. The series of reauthorization hearings we held this past year made clear the importance of a well-functioning transportation system to our nation's economy and quality of life. These hearings also laid out the challenges our transportation system faces due to increasing congestion, safety concerns, the deterioration of our infrastructure, and the rapid projected growth in freight movements. Finding the necessary funds to address these problems will be our toughest reauthorization challenge and I hope that we can work closely with the Budget Committee to ensure that we devote the maximum resources possible to maintaining and improving our transportation infrastructure.

Mr. BOND. Senator INHOFE accurately states that transportation dollars have a direct effect on jobs and the economy in this country. For example, earlier this year there was a proposed $8.6 billion reduction in fiscal year 2003 proposed spending from fiscal year 2002 enacted level for highways. This would cost an estimated 6,600 jobs in Missouri alone. Fortunately, the Environment and Public Works Committee in working with our colleagues on the Senate Transportation Appropriation Subcommittee have proposed full funding for fiscal year 2003.

More importantly, we need to recognize that our nation's transportation infrastructure is also an issue of safety. There is no question that increased investment in our nation's transportation system saves lives. For these reasons and more, I stand with my colleagues on Environment and Public Works in doing everything in our power to maintain a robust highway program as we go into reauthorization.

Mr. NICKLES. I appreciate my colleagues comments and agree with them that the revenues collected through the federal gas tax should be used to maintain and improve our transportation infrastructure. I will work with my colleagues to ensure this is the case.

CONGRATULATIONS TO JUDGE SERGIO GUTIERREZ

Mr. CRAIG. Mr. President, today I congratulate and honor a man whose contributions are an example to all of us. Idaho's Judge Sergio Gutierrez was recently recognized by Hispanic Business magazine as one the 100 most influential Hispanics.

Judge Gutierrez holds the distinction of being the first Hispanic judge in Idaho. A judge since 1993, he was appointed to the Idaho Court of Appeals in January of this year by Gov. Dirk Kempthorne. Sergio Gutierrez does a tremendous job as a judge, but his contributions go far beyond those he has made in his official capacity. Judge Gutierrez has worked to fight drugs, register voters, curb gang violence, and promote education, and he sits on the Governor's Coordinating Council for Families and Children. I am also honored that he serves as a member of my Hispanic advisory group in Idaho. His wisdom and advice have been invaluable assets as we have worked together to meet the needs of Idaho's Hispanic population.

It is hard to believe Judge Gutierrez was once a ninth grade dropout. However, with perseverance, he attained his GED, worked his way through college, and went on to graduate cum laude from Boise State University, later earning a law degree from Hastings Law School.

Judge Gutierrez believes in people, and he goes out of his way to help others overcome unfortunate circumstances that otherwise would limit their success. As a judge, he takes the opportunity to counsel with those who come into his court room. He often invites defendants into his chambers to discuss their futures, including drug rehabilitation, job training, and education. This is not a common practice among judges, but it has proven to be effective in the lives of the individuals whom Judge Gutierrez has touched.

I am proud to know Judge Sergio Gutierrez, and I would like to thank Hispanic Business magazine and its readers for recognizing this talented man. I would also like to thank Judge Gutierrez on behalf of the people of Idaho for the contributions he has made to our State and its people. He is truly an inspiring example for all of us.

A REMARKABLE AMERICAN: ROBERT INGRAM

Mr. HELMS. Mr. President, as my father always said, there are two types of people, talkers and doers. Anyone who knows Robert Ingram will agree with me that he is a ''doer extraordinaire.'' Bob, of course, is the distinguished Chief Operating Officer and President, Pharmaceutical Operations of GlaxoSmithKline, GSK.

A few weeks ago, October 15, Bob announced his intention to retire at year's end from his daily responsibilities as the second-highest executive officer at GSK, the world's premier pharmaceutical company. Through the years, GSK and more importantly, countless people around the world have benefitted immeasurably from Bob Ingram's compassion, energy, vision and intelligence.

In recent years, many politicians have engaged in a virtual sport, unjustifiably criticizing pharmaceutical companies and the senior executives who lead them. Thankfully, the American people have seen though many of these attacks for what they are, political expediency.

Americans are sophisticated enough to know that politicians do not develop life-saving and life-improving medications. Rather, it is the research-based pharmaceutical and biotech industries that invest billions of dollars each year to develop products that both extend our lives and improve the quality of life for billions of citizens around the world.

Bob Ingram has served as a beacon, consistently, respectfully and thoughtfully explaining the public health tradeoffs involved in implementing proposed new pharmaceutical regulations. It would be impossible to overstate his enormous contribution to reasoned discourse on this critical subject.

Bob Ingram has long understood that the ultimate victims of an inefficient and unproductive industry are the patients who will lack a safe and effective pharmaceutical therapy for the ailment that afflicts them not the pharmaceutical companies or their stockholders as some would have you believe.

Compassion requires that one stand up in support of what is proper. The measure of a leader is that he is willing to do so when that view is not popular. Bob Ingram has worked tirelessly as such a leader.

Fortunately, Bob's retirement from his day to day responsibilities at GSK will not mean that he is retiring from his role as an effective and outspoken advocate for the industry. Softening the blow somewhat is the knowledge that Bob will continue to fight for the well-being of patients as GSK's representative to the board of the Pharmaceutical Research and Manufacturer's Association.

Bob, his dear wife Jeannie, and GSK employees have long been involved in promoting service to others. Together with GSK's Chief Executive Officer, JP Garnier, Bob Ingram has done much to ensure that GSK serves as a global leader, launching effective medical programs that benefit millions of people throughout the world. The Orange Card discount program is a prime example of GSK's responsiveness and industry leadership in the United States.

Through GSK's Global Community Partnership programs, the Global Alliance to Eliminate Lymphatic Filariasis, a 20-year initiative to contribute hundreds of millions of doses of medication to rid the world of LF, the world's most disfiguring and disabling

disease, contributions of HIV/AIDS and anti-malarial medications as well as numerous other global, national, state and local initiatives, GSK employees have contributed greatly to the improvement of the human condition and human spirit.

Bob's life is a testament to the importance of setting the right priorities. He is a success professionally because his actions have demonstrated an extraordinary sense of personal responsibility to the improvement of the lives of others less fortunate.

Raised in rural Illinois, Bob Ingram is highly respected as one of North Carolina's leading citizens. He has devoted countless thousands of hours to worthy civic, community and professional organizations. For example, Bob led GSK's effort to provide a founders grant to the Emily Krzyzewski Durham family community center, he supported the Durham hill learning center and has helped numerous other local civic organizations around North Carolina.

The list of worthy national causes Bob has generously helped is so extensive that I will not attempt to recite them all. Bob's role as Chair of the CEO Roundtable on Cancer, his Presidency of the American Cancer Society Foundation, and his leadership in the fight to find a cure for cystic fibrosis, CF, merit particular note.

These past several years, Dot Helms and I have considered ourselves fortunate to call Bob and Jeannie Ingram our friends.

I am grateful for the positive contributions Bob has made during his tenure at GSK. His advice and support have been invaluable. His dedication to ensuring that people everywhere can benefit from advanced pharmaceutical therapies and his commitment to innovative programs that expand access to pharmaceuticals will continue to pay dividends to literally billions of people throughout the world for many years to come. Bob has achieved a remarkable, and I hope unfinished, legacy.

I ask unanimous consent that a transcript of Bob Ingram's comments at the National Press Club on July 18, 2002 and an article entitled ''A Retirement that hurts RTP'' from the October 16, 2002 edition of the Raleigh News and Observer be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

COMMENTS BY BOB INGRAM, NATIONAL PRESS CLUB, WASHINGTON, DC, JULY 18, 2002

Thank you, Mr. (John) Aubuchon, for your kind introduction and for providing me with an opportunity to address this important audience.

I'd also like to thank all of you for joining us this afternoon. I know you've heard a lot of criticism about the pharmaceutical industry and drug pricing. Today, I'd like to set the record straight.

It's hard to predict where the current debate over health care will eventually end up, or what the consequences will be. And I'm inclined not to predict such things unless I end up like Lord Kelvin, an English Scientist and president of the Royal Society, who has gone down in history for saying: ''Radio has no future. Heavier-than-air flying machines are impossible. X-rays will prove to be a hoax. I have not the smallest molecule of faith in aerial navigation other than ballooning.'' Now there's a man of conviction, but you certainly wouldn't want him betting for you at the racetrack.

That said, we Americans have a lot riding on the outcome of society's debate over how to control our healthcare costs—nothing less than the future health of ourselves and our children.

A key question in this current debate is: How much should we be spending on prescription drugs? Drug costs are skyrocketing, and payors are asking, how much is too much? Unfortunately, in focusing the debate almost solely on cost, it's easy to lose sight of the patient. Payors increasingly demand less expensive medicines, but it's easy to forget that a tiny pill often represents a scientific miracle in its ability to save lives and improve quality of life. As patients, we assume the research intensive pharmaceutical industry will find better treatments for cancer, and Alzheimer's and Parkinson's—but we don't recognize that paying for that research also means paying at the pharmacy counter. Do we spend more on pharmaceuticals today than we did years ago? Yes. In fact, our critics would say that we are spending too much on branded drugs.

But I would argue that rather than spending less, we should be investing more as a society on pharmaceuticals, because medicines actually represent the best value in healthcare today—for patients, and for payors.

Let's look at this issue of cost a little more carefully.

Between 1996 and 2000, national health spending for medicines increased 115 percent while overall health care costs increased 25 percent. Seems outrageous, doesn't it?

But let's put this in perspective. Total health care increased $260 billion during that time to a total of $1.3 trillion. Spending on pharmaceuticals was less than a 10th of that—$122 billion. In fact, of every dollar the government spends on health care, only 9 cents is spent on medicines—compared to 55 cents for doctors and hospitals. And that 9 cents includes the services of your pharmacist, plus current R&D efforts in our science labs. Unfortunately, people often confuse increased spending on drugs with increased prices for medicines.

The truth is that rising pressure on payor budgets is due to increased volume—more people using more and better medicines—not price increases on medicines. Pharmaceutical sales increased 19 percent in 2001 over 2000, but over 14% of that increase was volume growth. Less than 5 percent was due to price. So what accounts for the growth in volume? In great part, the very success of medicines in improving health and quality of life.

Those of you who are 45 or 50 . . . back at the turn of the last century, you'd be at the end of your life. But today, the majority of us can expect to blow out the candles on our 80th birthday cake. And we are part of a rapidly expanding group. Thirty-five million Americans are now over age 65; in just 30 years, that number will double to 70 million. Of course, if you're like me, you're tempted to ask why, if medicine has made so much progress in the past 50 years, how come I felt so much better 50 years ago.

Well the truth is, we Americans aren't just living longer; we are generally living healthier lives. Twenty years ago, in 1982, the average age of an elderly person entering a nursing home was 65. Today that age is 83. Many of you have elderly parents, and are perhaps caregivers. How important is it to you, and to your parents, that a few small pills can keep your loved ones living independently in the homes they've raised their families in, for as long as possible? But there's a cost to longer life, better health, and maintained independence—and somebody has to pay.

Industry critics say we can't afford this increased spending on pharmaceuticals. But what we really can't afford is the far greater cost of catastrophic care for heart disease, diabetes, Alzheimer's and other illnesses—costs that will grow substantially as the population grows. Let's consider diabetes.

Right now, we are facing an epidemic of Type II diabetes. Over 16 million Americans have Type II—the 5th leading cause of deaths by disease in the U.S. Another 16 million are estimated to have pre-diabetes, but most are not taking steps to avoid full onset.

We genuinely hope people will adopt preventive lifestyles to avoid the need for medicines. But those patients who do suffer with this chronic and progressive disease have a lot to look forward to Fatigue. Foot ulcers and gangrene leading to amputation. Blindness. Kidney failure. Heart disease. Stroke. Premature death. That's frightening for patients. But what will really frighten those responsible for paying for treatment is the alarming rise in the number of patients—and therefore costs—expected over the next 50 years. By then, at current rates, the number of patients with Type II diabetes will increase by 200 percent—skyrocketing our country's costs for dealing with Type II diabetes.

Today, we pay $100 billion a year to cover the human and economic cost to society from just this one disease—a huge proportion of which is spend for hospital care. When you consider the aging population, the increasing incidence of diabetes, and the huge cost associated with it, unless we come up with better answers, we'll break the bank with just one disease. That's what we can't afford.

But real hope lies in pharmaceuticals. Before 1995, doctors didn't have many options available. They relied primarily on insulin injections or sulfonylureas, as well as prevention. Just 7 years later, there are four new classes of oral diabetes medications on the market that help slow the progression of the disease, and prevent or delay the onset of its more serious and costly complications. Most importantly, these medicines ease patient suffering. And spending on these valuable medicines is only a fraction of the cost of fighting diabetes—just 2 percent in 1997. Can we afford to pay for new and better prescription medicines that fight diabetes? I would argue we can't afford not to. We have proven time and again that paying for medicines is the most cost effective way of fighting disease.

Take AIDS. Remember how, in the early 80's, full-blown AIDS was a death sentence for patients? Many died within two years of diagnosis. By 1996, AIDS had dropped out of the top 10 leading causes of death in the United States. Why?

In 1984, scientists at Burroughs Wellcome brought new hope to patients with AZT—the first treatment to fight HIV/AIDS. In the first 16 months after AZT came to market, hospital inpatient care dropped by nearly half (43%). Today, with a score of medicines on the market, if patients take their combination therapy as prescribed, they don' die of AIDS. Critics say these medicines cost a lot of money. And they do. Combination therapy—using several AIDS medicines at once to fight the disease—costs approximately $11,000 a year per patient. But before such therapies were available, an AIDS patient could account for $100,000 a year in hospital bills—until they died from the disease.

Are we spending more today on AIDS medicines? Yes, but we are saving millions in the overall cost of medical care. And people with AIDS are living—and they are productive members of their communities. Instead of planning for their funerals, they are planning for the rest of their lives.

Then there's stroke.

Breakthrough clot-busting medicines can stop some strokes before permanent brain damage occurs. The end result not only saves lives, but also saves dollars—$1,700 in drug therapy versus over $6,000 per patient in treatment costs. More promising yet, increased drug use may prevent some strokes entirely. A study by the Agency for Health Care Policy and Research says that greater use of a blood-thinning drug would prevent 40,000 strokes a year, saving $600 million per year. Yet stroke remains the 3rd leading cause of death for senior citizens and the first leading cause of disability. Without future breakthroughs from the research intensive pharmaceutical industry, we face huge future human and cost implications from this disease.

Are we spending more money on drugs to prevent and treat strokes? Absolutely. Is it worth it? Absolutely—both in terms of lowered costs and, more importantly, reduced patient suffering. Are we continuing to search for new and better treatment for stroke? Absolutely. But stroke is notoriously one of the most challenging types of pharmaceutical research and development to undertake. The incentives have to be there to justify the huge investment required in such high risk research. But if you're an insurance company, or an employer, or a federal or state government budget officer, you see the money spent on medicines going up and up, and a ballooning senior population in the offing, and you think, we've got to get this spending under control.

Your first response? Find any way you can to cut the pharmacy budget. You can do that a number of ways—price caps, supplementary rebates, formularies, for example—but the result can be unexpected.

Years ago, the state of New Hampshire learned this lesson the hard way. The government capped prescription drug spending, and saved an average $57 a year on drugs for schizophrenia patients. But the law of unintended consequences kicked in, and they added $1,500 a year in costs for visits to mental-health clinics and emergency rooms.

Ladies and gentlemen, that's what my mother called penny-wise and pound-foolish. Pharmaceuticals are actually the best value in health care, and rather than spending less, we should be investing more on medicines. Penny-wise squeezing of pharmaceutical costs only results in pound-foolish expansion of costs for more expensive health care procedures. Do we spend more on pharmaceuticals today than we did years ago? Yes. But we can't afford to forget that the money paid for medicines today fuels investment in R&D for the medicines of tomorrow.

You're all familiar with the floppy disks or CDs you use to load software on your computer. You also probably know that these disks cost less than a dollar to buy at your local office supply store. Why then does your software often cost hundreds of dollars? Well, for the same reason that a little white pill costs so much at the pharmacy. Just as in the case of new medicines that improve your health, hundreds of highly-skilled people took many years to invent and develop that new software for your computer. You're not just buying a bit of plastic. You're buying creativity, and years of research and development that went into developing the software for your computer—and the new medicines that improve your health.

In our case that's an investment of $800 million, 10–12 years of R&D, and the failure of 5,000 to 10,000 compounds along the way—just to bring one new innovative medicine to market. But it's government and academia that discover drugs, right? Not exactly. Of the top 100 most commonly used medicines in the U.S., 93 were discovered and/or developed by research-based pharmaceutical companies. Certainly, government and academia play a vital role in scientific research. They push the frontiers of science, and while we do that in pharmaceutical research companies too, we have the practical expertise to link what we know about disease and the human body to develop medicines that improve human health. For example, the public sector discovered the presence of beta adrenergic receptors in the heart and blood vessels. But it took the pharmaceutical research industry to convert that scientific knowledge into new medicines that treat heart disease, high blood pressure and stroke—the beta-blockers that are keeping a number of us, and our parents, alive today.

GSK alone invests $4 billion a year in research and development. The hope for patients who are or will suffer from diabetes, AIDS, Parkinson's, stroke, Alzheimer's, Cystic Fibrosis and countless other diseases lies in the powerhouse of innovative pharmaceutical industry research—and in the partnerships between industry, government and academia. Recently many of you have read or seen news items about an insurance industry-sponsored study claiming that all this research effort doesn't result in better drugs, but only drugs of minimal value—so-called me-too drugs. Breakthrough medicines are fantastic—when you find them—but they are rare, and very hard to achieve. Believe me, no one sets out to discover or develop a medicine that has no advantage over current therapy.

I sometimes say working in a pharmaceutical company is a lot like playing golf: It costs a lot and takes a long time to play. You will likely never hit a hole in one. And you always feel like you're playing with a handicap. But you can't escape the fact that science is slow and incremental. More often than not, after years of testing, you learn that your medicine isn't a breakthrough; but it may offer fewer side effects, work a little faster, or come in a pill that is easier for patients to swallow. These incremental advances—while not breakthroughs—can and do provide real value for patients. Sometimes we find new uses for old drugs. Take Coreg—a GSK treatment for heart failure. Coreg is a beta-blocker, a class of drugs which at one time was restricted to treating hypertension because it was thought to cause heart failure in patients. But clinical trials showed Coreg actually benefited patients with congestive heart failure.

These trials were so successful that the only ethical thing to do was to stop the trial and give the medicine to all patients, even those who were on placebo. If you work for an insurance company, you might view Coreg as a me-too drug. If you're a patient, you'd likely view it as a lifesaver. Our critics say that we should concentrate only on new chemicals, and forget such incremental gains. But consider this. Merck and GSK both have AIDS vaccines in development. One may work, neither may work, or both may work.

But right now we don't know which could be the miracle vaccine that makes it first to market and which would be the follower—a so-called me-too. Tell me. Which of these research programs should we kill for the purpose of controlling costs? Personally, for those at risk of AIDS, I hope both programs are a success, and that physicians and patients have a choice of two AIDS vaccines competing with one another in the marketplace. Of course, when we do come up with a new idea and patent it, our critics claim that we abuse the patient system for the purpose of keeping generic drugs off the market. Let me set the record straight. There is clearly a place for generics in our health care system.

I have no problem competing with generics in the marketplace—but only after our patent expires. There's a great deal of confusion about patents in the public mind, and that's understandable, because it's complex subject. First off, no innovator pharmaceutical company realizes a full 20 years of patent life on a medicine granted under the law. By the time that medicine makes it through the regulatory process, we only have about 11 years left on our 20 year patent to realize a return on that investment and fund current R&D. Other industries, by contrast, generally enjoy 18 years of patent life on their products.

Second, the Hatch Waxman Act of 1984 basically crated the generic industry by outlining a delicate balance between the need, on the one hand, to bring low cost copies to market after a medicine's patent expires, and on the other hand, to protect incentives for pharmaceutical research and innovation. History has proven one thing—thanks to the Hatch Waxman Act, the modern generic drug industry is healthy and growing. In fact, generics now account for nearly half of all prescriptions filled in the United States. Yet as part of that delicate balance, generic drug companies were given a special treatment unlike any other industry. They have access to patent protected date *before* the patent expires.

So a generic company can copy our scientists' work, develop their plans to manufacture their version of our medicine, and have it ready to ship the day the patent expires. In every other industry, a copier has to wait until the patent expires on a technology before they can even think about planning to copy that product. The problem is, generic companies don't want to wait until the patents expire. They have taken to challenging innovator patents in an attempt to declare those patent invalid so they can come to market sooner.

In the case of our anti-depressant, Paxil, the first generic company challenged our patents just five and a half years into what should have been a 14-year patent term. In the next 3 years, seven other generic companies entered the fray.

Ladies and gentlemen, this kind of abuse of the Hatch-Waxman Act means lots of time and money wasted on litigation, costs that eventually get reflected in the price of medicines. The first generic company to market often gets 6 months of exclusivity to sell their version of our product without competition from other generics—so contesting patents is worth it to those companies.

It's a much simpler and lower risk business strategy for [generic companies to] hire lawyers and challenge patents in the courts than to invest in science and final new innovative medicines.

Speaking for GSK, I'd be willing to consider giving up the defensive litigation provisions available to the research intensive industry under Hatch Waxman if the generic companies agree to drop the special provisions they have to come to market. Current reform efforts threaten to destroy the balance that protects innovation while enabling the generics to operate. In letter to Senator Kennedy, Richard Epstein, the James Parker Hall Distinguished Service Professor of Law at the University of Chicago, said it best: ''The current regime...confess competition with confiscation of property rights.'' It's important to remember that generic companies do not discover new medicines yet it's the innovative pharmaceutical research industry that is at risk. In fact, the patient

with a disease that needs a better treatment is at risk as well.

Let me close with where I started—with the idea that by focusing strictly on costs we are focusing on the wrong thing. Instead, we should be focusing on the patient. We need to be able to discover, develop, and deliver a better medicine that meets patient needs. To the degree we do that, we succeed. To the degree we don't do that, we fail. And when we fail, we fail patients who are suffering from disease. And we fail the society that looks to us for better treatments. I hope I've demonstrated that medicines offer the greatest value for better patient health and quality of life. But we do understand that if you can't afford your medicine, any price is too high. And that's why we at GSK—and at a number of other research-intensive pharmaceutical companies—are looking for ways to improve patient access to medicines, not only in developing countries, but here at home as well.

That's why we offer medicines to the most needy patients through our patient assistance programs. Last year, the innovative pharmaceutical industry helped to fill 6.5 million prescriptions for more than 2.4 million needy patients. That adds up to more than $1 billion worth of medicine provided free of charge. That's also why GlaxoSmithKline led the way in improving access to medicines for low-income seniors in the US.

GSK's Orange Card—the first savings card for seniors in the industry—offers low income seniors savings of 20–40% or more on more their GSK medicines. We now have over 100,000 seniors participating in this savings program. The Together Rx card does the same, but offers saving on more than 150 medicines from 7 different pharmaceutical companies. In less than six weeks after availability, over 1 million patients had requested enrollment forms for this program. Both cards are free, and easy to obtain and use. But such programs are only a stopgap until comprehensive Medicare reform can pass Congress.

Of course skeptics will say that passage of real Medicare reform is a bit like the story of the doctor who went to heaven and met God. God granted him one question, so the physician asked, ''Will health-care reform ever occur?'' ''I have good news and bad news,'' God replied. ''The answer is yes, there will be health care reform. The bad news is, it won't be in my lifetime.'' We in the research intensive industry hope passage of a meaningful benefit does occur, not just in our lifetime, but in this election year.

We understand passing reform of this magnitude in an election year can be a challenge. But we strongly favor adding a drug benefit to Medicare, because we believe patients should have coverage for health care—including prescription drugs. The House has already passed a bill which we supported. We hope that the Senate, in an election year, would put patients first and also pass meaningful reform, like that embodied in the tripartisan bill that Democrats, Republicans and Independents are supporting. That bill provides a meaningful benefit, but allows competition to take place in the free market. That type of arrangement allows real price competition, in the marketplace, but does not stifle innovation and research. That's where we stand now. We must come to grips with the cost side of the value equation if we are to restore balance and realize the true value of the medical innovations we have the opportunity to enjoy.

If we at GSK are ever inclined to forget the value of our medicines, we have to look no further for a reminder than the patients we serve today. I was astonished by an e-mail we received from a woman who takes Advair—our newest asthma medicine. She wrote; ''I started taking Advair approximately August 24th. I really began feeling great—my breathing had improved immensely. On September 11th, I was in 2 World Trade Center when the impossible happened. I really believe that because of this medication I was able to make my way down 59 stories through Manhattan and across the Brooklyn Bridge. Please give my thanks to those who developed this life saving medicine.''

This letter means a lot to me, and to all of us at GSK—particularly our scientists who dedicate their lives to discovering and developing new medicines like Advair.

Just yesterday, a Wall Street Journal editorial cited one of our industry's best critics, Sen. Edward Kennedy, saying that ''something has to be done about the 'soaring cost of prescription drugs' else the 'miracle cures' promised by the biotech revolution will remain priced 'out of the reach of ordinary Americans.' '' The editorial went on to say: ''Miracles they may be, but they don't fall from heaven. They will be developed for a profit, or they won't be developed at all.''

Thank you.

[From Newsobserver.com, Oct. 16, 2002]

A RETIREMENT THAT HURTS RTP

(By David Ranii)

RESEARCH TRIANGLE PARK.—Robert Ingram, the No. 2 executive at giant GlaxoSmithKline and the most visible pharmaceutical industry leader in the Triangle, is retiring at the end of this year.

Ingram, who in December turns 60, mandatory retirement age for GSK executives, is the former chief executive officer of London-based Glaxo Wellcome and was named chief operating officer and president of worldwide pharmaceutical operations after Glaxo merged with SmithKline Beecham nearly two years ago.

David Stout, now president of the U.S. pharmaceuticals business, will replace Ingram as head of worldwide pharmaceuticals.

''I think Bob is one of the most outstanding pharmaceutical executives in the United States,'' said John Plachetka, chief executive of Durham pharmaceutical company Pozen. ''He is so well known and well respected—not just in our industry but in Washington.''

As the highest-ranking former Glaxo executive remaining at GSK, Ingram's imminent retirement can be viewed as reinforcing the complaints of some employees that what was billed as a merger of equals has turned out to be a de facto takeover by SmithKline Beecham. Glaxo's former chairman, Richard Sykes, retired from GSK earlier this year. Ingram will continue to work with the company as part-time vice chairman and special adviser.

Ingram's retirement sets off a domino effect among senior executives at GSK, which is based in London and has twin U.S. headquarters in Research Triangle Park and Philadelphia.

Unlike Ingram, whose office is in RTP, Stout, 48, will move to Philadelphia when he takes charge. Stout hails from the Smithkline Beecham side of the business and was based in Philadelphia before being named to his current post in January 2001.

Ingram said he has ''a high degree of confidence in David's ability.''

Stout's successor as head of the U.S. pharmaceuticals business will be Christopher Viehbacher, 42, president of pharmaceuticals in Europe, who will move from Paris to RTP. Andre Witty, Asia Pacific senior vice president, has been named Viehbacher's successor. Both Viehbacher and Witty were with GSK before the merger.

After Ingram retires, six of the 14 top-tier executives at the company, what the company calls its corporate executive team, will have Glaxo Wellcome pedigrees, while the other eight will share a SmithKline Beecham heritage. Ingram, meanwhile, will continue to participate in executive team meetings even after he retires, said GSK spokeswoman Mary Anne Rhyne.

The chief operating officer position being vacated by Ingram isn't being filled.

Ingram, who began his pharmaceutical career as a sales representative, said that when he left Merck & Co. to join Glaxo in 1990, he realized that the one downside was that Glaxo, like many British companies, had a mandatory retirement age of 60 for top executives. ''Time, unfortunately, marches on, as they say,'' he said.

Ingram said that, although he doesn't have a noncompete clause in his new arrangement with GSK, he isn't interested in being CEO of another pharmaceutical company. ''I will say I have been approached to do that,'' he said. ''It is flattering.''

''There is certainly a possibility,'' he added, ''that I might take on some nonexecutive chairmanships.''

Ingram, who is well known in political circles, also said he has no plans to run for political office. ''I think my wife would shoot me if I even considered it,'' he said.

Ingram has earned kudos for being an effective advocate for GSK and the industry in Washington, and he also has developed a relationship with President Bush and his family. At a black-tie GOP fund-raiser held in Washington in June that netted about $30 million, Ingram was called upon to offer the presidential toast.

In recognition of Ingram's Washington clout, he will remain GSK's representative on the board of the industry trade group, Pharmaceutical Research and Manufacturers' Association, after his retirement.

''Bob Ingram is one of the giants of the pharmaceutical industry, and we are pleased that he will continue to play a major role on the PhRMA Board,'' Alan Homer, the association's president, said in a statement. ''Bob's sensitivity and caring for the needs of others, especially patients, is unparalleled.

Dr. Charles Sanders, a former chairman and chief executive of the U.S. operations of what is now GSK, praised Ingram's leadership. ''Bob has been through two mergers, first with Burroughs Wellcome and then with SmithKline Beecham,'' said Sanders. ''I think he has handled it very well. it is very difficult to merge companies.''

Ingram, who lives in Durham, said he understands that some GSK employees keep score regarding how many former Glaxo Wellcome executives are in leadership positions compared with their counterparts from SmithKline Beecham. But that's not how the corporate executive team looks at things, he said.

''It is one company: GSK,'' he said. ''Our competition isn't internal. The last time I checked, we had plenty of competition [elsewhere].''

FOSTERING DEMOCRATIC PRINCIPLES AND VALUES IN UKRAINE

Mr. SESSIONS. Mr. President. I wish to bring to the attention of my colleagues the Civitas International Civic Education Exchange Program, a cooperative project of civic education organizations in the United States and other nations. The goal of the project is to exchange ideas, experiences, and curricular programs to further the development of civic competence and responsibility among youth in emerging